COMMONWEALTH of VIRGINIA

Department for the Aging

Jay W. DeBoer, J.D., Commissioner

TABLE OF CONTENTS
AAA TUESDAY MAILING
December 9, 2003

SUBJECT	VDA ID NUMBER
2004 Older Americans Month Theme (Bill Peterson)	04-47
Governor Warner's Tax Reform Proposal (Bill Peterson)	04-48
Regional Budget Hearings (Bill Peterson)	04-49
FY 2004 Federal Appropriation (Jane Snead)	04-50
Arkansas Cash and Counseling Program Evaluation (Ellen Nau)	04-51

1600 Forest Avenue, Suite 102, Richmond, Virginia 23229
Telephone (804) 662-9333 (V/TTY) Fax (804) 662-9354 Toll-Free (800) 552-3402 (V/TTY)

Virginia department for the Aging

COMMONWEALTH of VIRGINIA
Department for the Aging
Jay W. DeBoer, J.D., Commissioner

MEMORANDUM

TO: AAA Directors

FROM: Bill Peterson

DATE: December 9, 2003

SUBJECT: **2004 Older Americans Month Theme**

The Assistant Secretary for Aging, Josefina G. Carbonell, has announced the theme for Older Americans Month 2004: ***Aging Well, Living Well***. This theme has been selected to celebrate and recognize older Americans who are living longer, healthier, and more productive lives.

Over the next several months, we will share more information about the Administration on Aging's plans in recognition of Older Americans Month 2004. You can also go to http://www.aoa.gov/.

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COMMONWEALTH of VIRGINIA
Department for the Aging
Jay W. DeBoer, J.D., Commissioner

MEMORANDUM

TO: AAA Directors

FROM: Bill Peterson

DATE: December 9, 2003

SUBJECT: **Governor Warner's Tax Reform Proposal**

In a presentation to the Commonwealth Council on Aging at their quarterly business meeting on December 12th, Secretary of Health and Human Resources, Jane Woods, promoted the Governor's tax reform proposal. She told Council members that unless some form of tax reform along the lines that the Governor is proposing is implemented, state agencies can expect additional budget cuts in the range of 12-15%. She went on to say that these cuts would have to be taken in services because there were no more state administrative funds available for cuts.

To learn ore about the Governor's proposal, go to: http://www.governor.virginia.gov/Initiatives/TaxReform/index.htm.

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COMMONWEALTH of VIRGINIA
Department for the Aging
Jay W. DeBoer, J.D., Commissioner

MEMORANDUM

TO: AAA Directors

FROM: Bill Peterson

DATE: December 9, 2003

SUBJECT: **Regional Budget Hearings**

House Appropriations and Senate Finance Committee members will hold regional public hearings on the Governor's proposed amendments to the 2002-2004 state budget (which will be released on December 17th). Hearings have been scheduled for the following dates and locations:

Tuesday, January 6, 2004 beginning at 12:00 Noon

- Northern Virginia Community College, Woodbridge Campus, Auditorium (room 120), Seefeldt Building.
- Patrick Henry Community College, Walker Fine Arts Center.
- Christopher Newport University, Gaines Theater in Student Center.
- Augusta County Government Center in Verona, Board Room.

Monday, January 19, 2004 beginning at 1:00 PM

- General Assembly Building in Richmond, House Room D.

1600 Forest Avenue, Suite 102, Richmond, Virginia 23229
Telephone (804) 662-9333 (V/TTY) Fax (804) 662-9354 Toll-Free (800) 552-3402 (V/TTY)

In addition to these posted meeting dates, I believe that an additional hearing will be scheduled somewhere in Southwest Virginia. I will let you know if and when this hearing is scheduled.

Members of the **Commonwealth Council on Aging** will be attending these budget hearings and have been encouraged to contact you so that a combined and concerted presentation may be made. The money committee members respond to public pressure….so it behooves our network to make an effort to bring board members, staff, and clients to these hearings.

Speakers will be taken in order of registration. Each person may only register one speaker at a time….so it is important to coordinate who and how many persons will be speaking for our network. It is important to sign up early….so if the meeting is scheduled for Noon, you may want to send someone as early as 11:00 AM (or earlier) to sign your speakers up!

To arrange for special accommodations for persons with physical disabilities, call 804-698-7480 by 5:00 PM on Monday, December 22nd.

Written comments may also be submitted. Send them to Budget Hearings, c/o Delegate Vincent F. Callahan, Jr., PO Box 406, General Assembly Building, Richmond, VA 23218.

COMMONWEALTH of VIRGINIA
Department for the Aging
Jay W. DeBoer, J.D., Commissioner

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Jane Snead
Contract Coordinator

DATE: December 9, 2003

SUBJECT: FY 2004 Federal Appropriation

The November 25, 2003 Congressional Record shows FY 2004 aging funding from the Conference Agreement. There is an overall .59% across the board reduction that applies to all programs that is not reflected in the numbers. Therefore we've prepared the attached chart that shows FY'03 funding, the conference agreement, the conference agreement with the .59% reduction and the change in dollars and percentage. You can review the Congressional Record at **http://www.gpoaccess.gov/crecord/index.html**. Type in the search box "Administration on Aging Conference".

jas

Attachment

1600 Forest Avenue, Suite 102, Richmond, Virginia 23229
Telephone (804) 662-9333 (V/TTY) Fax (804) 662-9354 Toll-Free (800) 552-3402 (V/TTY)

FY 2004 Appropriations
December 3, 2003
(dollars in thousands)

Older Americans Act	Enacted FY'03	Conference Agreement	Conference Agreement with .59% Reduction	Difference in FY'03 and Conference with Reduction	% Change
Title III					
Supportive Services and Centers	355,673	356,000	353,900	-1,773	-0.499
Congregate Meals	384,592	388,646	386,353	1,761	0.458
Home Delivered Meals	180,985	180,985	179,917	-1,068	-0.590
Nutrition Services Incentive Program	148,697	149,073	148,193	-504	-0.339
Preventive Health	21,919	21,562	21,435	-484	-2.209
Family Caregivers	149,025	153,645	152,738	3,713	2.492
Native American Caregivers	6,209	6,355	6,318	109	1.748
Title IV					
Aging Research and Training	40,258	33,223	33,027	-7,231	-17.962
Title VI					
Grants to Indians	27,495	26,612	26,455	-1,040	-3.783
Title VII					
Ombudsman/Elder Abuse	18,559	19,559	19,444	885	4.766
Ombudsman		14,361			
Elder Abuse		5,198			
Aging Network Support	2,364	13,373	13,294	10,930	462.356
(Pension Counseling/Eldercare Locator)					
Alzheimer's Initiative	13,412	11,956	11,885	-1,527	-11.382
Program Administration	17,869	17,501	17,398	-471	-2.637
White House Conference on Aging		2,842	2,825	2,825	
Total: AoA Programs	**1,367,057**	**1,381,689**	**1,373,537**	**6,480**	**0.474**
Title V Senior Employment	442,207	441,253	438,650	-3,557	-0.804
Social Services Block Grant	1,700,000	1,700,000	1,689,970	-10,030	-0.590
LIHEAP	1,700,000	1,900,000	1,888,790	188,790	11.105

From the Congressional Record - 11/25/03

Notes: 1) Aging Program Support reflects shifted funding for the National Ombudsman Resource Center, the National Center on Elder Abuse and the Medicare Waste Patrol program from Title IV to the Aging Network Support program.
2) Total: AoA Programs - Conference Agreement column does not total correctly due to rounding.

jas

12/4/2003

COMMONWEALTH of VIRGINIA
Department for the Aging
Jay W. DeBoer, J.D., Commissioner

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Ellen Nau, Human Services Program Coordinator

DATE: December 9, 2003

SUBJECT: Arkansas Cash and Counseling Program Evaluation

Researchers at Mathematica Policy Research in Princeton, New Jersey have evaluated the Arkansas Cash and Counseling Program. A Health Affairs Web Exclusive article with the researchers evaluation can be accessed at **www.healthaffairs.org**. A .pdf version of the article is attached.

The Arkansas Independent Choices Cash and Counseling Program is one of the three Cash and Counseling Demonstration Programs sponsored by the Department of Health and Human Services and the Robert Wood Johnson Foundation. Cash and Counseling Programs gives eligible participants a flexible monthly allowance to purchase disability related goods and services. Critics of cash and counseling programs worry that participants might mismanage their funds, purchase inadequate care or pay family members to provide services that they received for free.

Mathematica researchers reported in a prior article that the Arkansas program greatly increased client satisfaction and reduced clients' unmet needs for many types of services. The current Health Affairs article notes that Medicaid personal care recipients using cash and counseling had higher expenditures than those not in the Independent Choices Program. During the second year of participation though, lower spending for other Medicaid services and nursing homes negated the previous year's higher expenditures for personal care. The Arkansas Independent Choices program was open to adults eighteen years or older and eligible for personal care under the state's Medicaid plan. 2,008 beneficiaries (about 11% of personal care services users) enrolled in the cash and counseling program between December 1998 and April 2001.

The Effects Of Cash And Counseling On Personal Care Services And Medicaid Costs In Arkansas

Arkansas' experience shows that states can develop consumer-directed services at no greater cost than traditional agency care.

by Stacy Dale, Randall Brown, Barbara Phillips, Jennifer Schore, and Barbara Lepidus Carlson

ABSTRACT: The Cash and Counseling Demonstration gives Medicaid beneficiaries who are eligible for personal care services a consumer-directed allowance in lieu of traditional agency services. Using survey and Medicaid claims data on 2,008 adult applicants randomly assigned to treatment or control groups, we find the program increased the receipt of paid care but reduced unpaid care. The treatment group had higher Medicaid personal care expenditures than controls did, because many controls received no paid help, and recipients obtained only two-thirds of entitled services. By the second year after enrollment, these higher personal care expenditures were offset by lower spending for nursing homes and other Medicaid services.

MEDICAID PERSONAL CARE SERVICES (PCS) assist beneficiaries with routine activities, such as bathing and getting in and out of bed. These services are intended to improve beneficiaries' quality of life and allow them to live in their homes, rather than in nursing facilities. However, beneficiaries often do not receive authorized services, which raises concerns about whether they receive adequate care.[1] Moreover, because the PCS benefit is traditionally provided through agencies, beneficiaries' choices are sometimes limited about how and when their care is provided, especially since agencies generally do not provide care on weekends or outside normal business hours. Finally, the PCS benefit does not cover assistive technologies or home modifications that could reduce dependency on human assistance.

Stacy Dale is a researcher at Mathematica Policy Research in Princeton, New Jersey. Randall Brown, rbrown@mathematica-mpr.com, is a senior fellow there and the project's director and co–principal investigator. Barbara Phillips is the study's principal investigator; she is an independent consultant in San Diego, California. Jennifer Schore is a senior researcher and the deputy project director at Mathematica, in Princeton, and Barbara Lepidus Carlson is a senior sampling statistician and survey director there.

DOI 10.1377/hlthaff.W3.566

"Advocates for consumer-directed care believe that individuals are best suited to make decisions about the care they receive."

States are increasingly interested in improving the well-being of beneficiaries who are eligible for PCS by allowing them to plan and direct their own care. Advocates for consumer-directed care believe that individuals, not agencies, are best suited to make decisions about the care they receive and the workers they hire. However, critics are concerned that consumers might misuse the funds intended for their care, receive inadequate care, or use a cash benefit to pay family members to provide care once provided for free. States are wary that the program might raise total Medicaid costs.

The national Cash and Counseling Demonstration permits the first rigorous comparison of PCS use under agency- and consumer-directed approaches. In a previous *Health Affairs* paper we showed that the IndependentChoices program in Arkansas, the first of the three states to implement the demonstration, greatly improved consumers' satisfaction and reduced their unmet need for many types of assistance without increasing their likelihood of experiencing adverse health problems.[2] Our current paper explores the program's effect on the receipt, timing, and amount of PCS that beneficiaries receive; the modifications and purchases they make to help them perform daily activities independently; and their Medicaid expenditures for personal care and other services.

Background

The Cash and Counseling model of consumer-directed supportive services gives eligible beneficiaries who choose to participate a flexible monthly allowance to purchase disability-related goods and services (including hiring relatives as workers). The program also provides counseling and fiscal assistance and allows consumers to designate representatives (such as family members) to make decisions on their behalf. These features make the model adaptable to consumers of all ages and with all types of impairments.

Arkansas' IndependentChoices was open to adults who were at least eighteen years old and who were eligible for PCS under the state's Medicaid plan. About 11 percent of PCS users (2,008 beneficiaries) in Arkansas enrolled in the demonstration between December 1998 and April 2001. Enrollees completed a baseline telephone interview and were then randomly assigned to the treatment or control group. Control-group members continued relying on agency services or, if newly eligible for Medicaid PCS, received a list of home care agencies to contact for first-time services. Treatment group members were contacted by an IndependentChoices counselor, who helped them develop written plans for spending their allowance. Allowance spending plans could include hiring workers (excluding spouses or representatives) and purchasing other services or goods related to their

needs, such as supplies, assistive devices, and home modifications. Counselors also monitored satisfaction, safety, and use of funds.

Data Collection And Methods

We drew data from two computer-assisted telephone surveys of enrollees (a baseline survey and a follow-up survey conducted nine months after each sample member's random assignment) and from Medicaid claims data. Service-use outcomes (including the type, timing, and amount of assistance received and the purchases made) were constructed from the nine-month survey, which was completed by 87 percent of the full sample. Data on spending for personal care and other Medicaid services were drawn from Medicaid claims data for the twelve months after enrollment for the full sample and for the twenty-four months after enrollment for a cohort of "early enrollees" (those who enrolled before May 2000).

PCS expenditures recorded in the claims data for those receiving agency services were equal to actual hours of care delivered, multiplied by $12.36, the rate paid by Arkansas Medicaid for agency services. PCS expenditures for treatment-group members receiving the allowance included the amount of the allowance itself, plus fiscal agent and counseling fees. Arkansas set the allowance equal to $8, times the number of care plan hours (discounted to reflect the historic difference between the hours of care agencies actually delivered and care plan hours). Counseling and fiscal agent fees were expected to be covered, in the aggregate, by the difference between Medicaid's $12.36 per care plan hour and the $8 per hour allowance. (Treatment-group members did not have to actually use their allowance to purchase the number of hours of care in their care plan, nor did they have to pay wages of $8 per hour.) Treatment-group PCS expenditures also included any payments to agencies for services delivered after randomization but before consumers' allowance started or, for disenrollees, after leaving the program.

We estimated program impacts using linear regression and logit models that controlled for the sample member's baseline characteristics, including measures of demographic characteristics, care plan hours, health and functioning, use of personal assistance, satisfaction with care and life, unmet needs, and work and community activities. As expected under random assignment, the characteristics of the treatment and control groups were very similar; our models ensure that any differences between the two groups in these characteristics that might have arisen by chance or by different nonresponse patterns do not distort our estimates.[3] We estimate effects separately for elderly and nonelderly adults because the types and amounts of care they need could differ.

Study Results

■ **Likelihood of receiving paid assistance.** IndependentChoices greatly increased the likelihood that beneficiaries received paid assistance. Elderly community residents in IndependentChoices were much more likely than controls were to

receive paid assistance during their two most recent weeks at home prior to the nine-month interview (Exhibit 1). The difference for the nonelderly was even larger.

The lack of any paid assistance among control-group members was striking, particularly among "new applicants"—those who were not receiving publicly funded home care services when they enrolled in the demonstration (about a quarter of the sample). Fifty-one percent of new applicants in the control group, compared with only 8.1 percent of new applicants in the treatment group, did not have a paid caregiver nine months after enrollment (data not shown), despite being eligible for PCS. Among those receiving publicly funded home care at enrollment, the treatment-control difference in the percentage of consumers without paid assistance at nine months was statistically significant but much smaller (5.1 percent for treatments versus 13.7 percent for controls). Among treatment-group members, about two-thirds hired family members, and most others hired friends or acquaintances (data not shown). A minority of those hired lived with the treat-

EXHIBIT 1
Estimated Effects Of IndependentChoices On The Receipt, Timing, And Amount Of Assistance Received In The Previous Two Weeks, 1999–2002

	Ages 18–64 (n = 473)		Age 65 and older (n = 1,266)	
Outcome	**Predicted treatment-group mean**	**Predicted control-group mean**	**Predicted treatment-group mean**	**Predicted control-group mean**
Lived in the community	93.1%	95.7%	86.1%	87.8%
Of those living in the community				
Received paid assistance	94.5%	67.8%****	94.2%	78.8%****
Received unpaid assistance	97.1	95.0	93.7	90.5*
Received assistance				
On weekday evenings	80.2%	75.0%	73.2%	68.3%**
On weekends	85.4	79.1*	78.2	76.2
Early mornings/evenings or weekends	90.7	81.8***	80.2	78.2
Total hours of care	99.3	120.0**	125.3	128.8
Paid hours	24.7	22.2	23.3	16.6****
Unpaid hours	74.6	97.8**	102.0	112.1
Total help received (hours)[a]				
0–42 (0–3 per day)	34.7%	36.0%	34.1%	36.4%
43–126 (3–9 per day)	35.1	23.2	23.2	19.8
127–210 (9–15 per day)	20.7	23.7	19.0	18.9
210+ (15+ per day)	9.5	17.1	23.7	24.9
Paid hours among those with paid care received[a]				
1–14 (<1 per day)	17.9%	30.7%	17.5%	38.5%
15–70 (1–5 per day)	76.3	55.9	77.9	56.1
70+ (5+ per day)	5.8	13.4	4.7	5.4

SOURCE: Nine-month evaluation interview, conducted by Mathematica Policy Research between September 1999 and March 2002.

NOTES: The analysis of hours of care received includes only the 421 nonelderly and 1,138 elderly sample members who had complete data for each component of total hours. Asterisks denote statistically significant effects of treatment-group status.

[a] Chi-square tests of the treatment-control differences in the distribution of total hours of help received and hours paid for were performed for each of the age categories. *P*-values were < .01 except for total help received, ages 65 and older ($p = .550$).

*$p < .10$ **$p < .05$ ***$p < .01$ ****$p < .001$

ment-group member.

■ **Hours during which care was received.** IndependentChoices addressed a limitation of agency care for some: access to care during nonbusiness hours. Among the elderly sample, treatment-group members were more likely than controls were to receive assistance during the evening (Exhibit 1). For the nonelderly sample, the treatment group was more likely to receive assistance during any nonbusiness hours (early morning, evening, or weekend).

■ **How personal assistance needs were met.** IndependentChoices affected the way that nonelderly people met their personal assistance needs. Nonelderly treatment-group members received an average of 99.3 total hours of care during the previous two weeks, 20.8 fewer than nonelderly control group members (Exhibit 1). This difference stems from the fact that a far greater percentage of the control group than the treatment group received more than 210 hours of help.

Nonelderly treatment- and control-group members received comparable amounts of paid care, but the treatment-group members averaged 23.2 fewer hours of unpaid care than control-group members. Among those receiving paid assistance, treatment-group members were less likely to get very high or low levels of paid care; this was largely attributable to the fact that control-group members who qualified for many hours of paid care were much more likely to actually receive paid assistance.

Nonelderly treatment-group members might have received fewer hours of total care because they reduced their need for human assistance. Treatment-group members were more likely than control-group members to obtain equipment to help with personal activities and communications, such as specialized telephones, lifts, or emergency response systems (Exhibit 2). The program also increased the proportion of nonelderly consumers making any purchase or modification.

For the elderly, the number of paid hours of care is about 40 percent greater for the treatment group than for the control group, but total hours of care are essentially equivalent for the two groups. The program had no effect on the purchases or modifications made by the elderly.

■ **Impact on Medicaid spending.** Medicaid expenditures were larger for the treatment group because the control group received a smaller-than-expected share of the services authorized for them. Control-group members received much less care than was authorized, resulting in annual PCS spending per sample member that was almost twice as high for the treatment group as for the control group during the first postenrollment year (Exhibit 3). The $2,256 difference in PCS spending was partly offset by a $421 reduction in spending for non-PCS long-term care Medicaid services (including nursing facility, home health, and other home health waiver programs called Alternatives and ElderChoices) and by a $348 reduction in other non-PCS Medicaid spending (driven mainly by hospital inpatient services). Thus, total annual Medicaid spending per sample member was $1,486 higher for the treatment group ($1,693 for the elderly and $1,294 for the nonelderly) (data not shown).[4]

EXHIBIT 2
Estimated Effects Of IndependentChoices On Home Modifications And Equipment Purchases Or Repairs, 1999–2002

	Ages 18–64 (n = 473)			Age 65 or older (n = 1,266)		
Outcome since enrollment	Predicted treatment-group mean (%)	Predicted control-group mean (%)	Estimated effect (p-value)	Predicted treatment-group mean (%)	Predicted control-group mean (%)	Estimated effect (p-value)
Modified house	30.1	26.2	3.8 (.338)	28.0	25.0	3.0 (.223)
Modified car or van	2.7	5.1	−2.4 (.131)	3.6	2.5	1.1 (.299)
Obtained special equipment or supplies for meal preparation or housekeeping	20.9	15.6	5.2 (.140)	12.7	12.9	−0.2 (.901)
Obtained equipment or supplies to help with personal activities/ communication	29.3	21.2	8.0 (.043)	28.3	31.2	−2.8 (.263)
Repaired equipment used to help client	20.5	17.4	3.0 (.372)	12.3	13.1	−0.8 (.665)
Modified home or vehicle or purchased any equipment or supplies	60.2	49.6	10.7 (.013)	55.0	54.5	0.5 (.855)

SOURCE: Nine-month evaluation interview, conducted by Mathematica Policy Research between September 1999 and March 2002.

The lower long-term care costs for treatment-group members suggest that Cash and Counseling enables consumers to substitute personal care services at home for other, more costly services, particularly nursing facilities. To assess whether such savings grow over time, we examined costs during the second postenrollment year for sample members whose Medicaid data were available in time for this analysis. For this early cohort (about half the sample), results for the first year were similar to those for the full sample, but total Medicaid spending during the second year was only 5 percent ($528) higher for the treatment group than for the control group, a statistically insignificant difference. While the treatment group's average PCS spending was $2,014 higher than that of the control group, treatment-group members' spending for non-PCS long-term care services was $1,057 lower, and their spending for other non-PCS services were $429 lower.

The higher PCS spending under IndependentChoices is not surprising, given the much higher proportion of treatment-group members receiving paid care. About half of the cost difference is attributable to the difference in the proportion receiving care. The remainder is attributable to treatment-group recipients' higher PCS spending than control-group recipients, as reflected in the treatment group's higher cost per person month of PCS benefit received—$445 for the treatment group versus $359 for controls, a 24 percent difference (data not shown).

The difference in cost per person month of PCS benefits is surprising because the two groups had equal average hours per month in their care plans at enrollment (about forty-five), and the cash allowance was discounted to account for the historical discrepancy between planned and actual hours. However, during

EXHIBIT 3
Estimated Effects Of IndependentChoices On Medicaid Spending, 1999–2002

	Predicted treatment-group mean ($)	Predicted control-group mean ($)	Estimated effect ($) (p-value)
Full sample: first-year postenrollment spending (n = 2,008)			
PCS spending	4,605	2,350	2,256 (.000)
Non-PCS long-term care Medicaid spending[a]	3,084	3,505	−421 (.023)
Other non-PCS Medicaid spending[b]	4,791	5,139	−348 (.109)
Total Medicaid spending	12,480	10,994	1,486 (.000)
Early cohort: first-year postenrollment spending (n = 1,312)			
PCS spending	4,855	2,402	2,452 (.000)
Non-PCS long-term care Medicaid spending[a]	2,892	3,396	−505 (.025)
Other non-PCS Medicaid spending[b]	4,576	5,142	−566 (.044)
Total Medicaid spending	12,322	10,940	1,386 (.001)
Early cohort: second-year postenrollment spending (n = 1,312)			
PCS spending	3,853	1,839	2,014 (.000)
Non-PCS long-term care Medicaid spending[a]	3,253	4,310	−1,057 (.003)
Other non-PCS Medicaid spending[b]	4,212	4,640	−429 (.182)
Total Medicaid spending	11,317	10,789	528 (.339)

SOURCE: Medicaid claims data.

NOTES: Those in the "early cohort" enrolled in the Cash and Counseling Demonstration before May 2000. Means were predicted using ordinary least squares (OLS) regression models. Elderly and nonelderly subgroups are combined here, because treatment-control cost differences were similar for the two groups. PCS is personal care services.

[a] Includes spending for nursing facilities, home health services, and the ElderChoices and Alternatives waiver programs.

[b] Includes spending for hospital inpatient services, prescription drugs, physician services, durable medical equipment, hospice, and other Medicaid services.

months when they received PCS, control-group members received an average of only 68 percent of their authorized care plan hours; historically, PCS recipients in Arkansas had received an average of 86 percent of their authorized hours. Thus, treatment-group spending per recipient was greater than control-group spending, because agencies delivered only 79 percent of the care they were expected to ($0.68/0.86 = 0.79$).

Discussion

Our study addressed one program in one state over a limited time period. Impacts might differ for programs with other features (for example, those that target children, allow spouses to be paid workers, or have more or less generous PCS benefits). Furthermore, our findings can be generalized only to the extent that demonstration participants are representative of those who would enroll in an ongoing program. Finally, estimated program effects might depend in part on whether the local supply of home care workers is adequate to meet the demand for

"IndependentChoices increased the likelihood that consumers received the help they needed, but with fewer hours of assistance."

services. Thus, results might be quite different for 2003 than they were for the 1999–2002 period studied here, when the labor market was quite tight. Future analyses will assess the robustness and generalizability of the findings by examining the effects of Cash and Counseling on adults in the other two demonstration states—Florida and New Jersey—and on children in Florida.

Although the generalizability of the results is uncertain as yet, the findings for IndependentChoices are clear: The program greatly increased consumers' access to care and ability to purchase needed equipment and supplies. However, the results raise two issues that could concern policymakers: (1) Paid care could substitute for previously unpaid care, and (2) consumer direction could raise Medicaid spending.

■ **Paid and unpaid care.** Both elderly and nonelderly treatment-group members received fewer hours of unpaid care than controls received. However, the great majority of their total hours of assistance still were provided by unpaid helpers. The reduction in hours of unpaid care, including some substitution of paid for unpaid help, is consistent with easing the burden on family caregivers, which is a generally accepted goal of publicly funded home care.

The program also reduced total hours of care for the nonelderly. This would be disturbing if the decrease in hours had been accompanied by an increase in the unmet needs or adverse events among consumers. However, our companion research showed that IndependentChoices decreased consumers' unmet needs, increased their satisfaction with care, and did not increase the likelihood of the adverse health events we examined.[5] Taken together, these findings suggest that IndependentChoices increased the likelihood that nonelderly consumers received the help they needed, but with fewer hours of human assistance.

How might these nonelderly consumers be meeting their needs more effectively than control-group members but requiring less assistance? First, by increasing the percentage of the nonelderly that purchased equipment, IndependentChoices might have decreased the need for human assistance. For example, a number of consumers purchased microwave ovens and washing machines, so that they could prepare meals and do laundry without help. Second, agency workers are often restricted from performing certain tasks, such as administering medication or providing transportation, while the treatment group's workers were not so restricted. Thus, because a single caregiver can perform a variety of tasks in one visit, care might be provided more efficiently under consumer direction. Finally, workers hired by consumers might have provided more and better care than agency workers, in less time.

■ **Medicaid spending.** The second concern is that Medicaid spending for PCS

during the year after enrollment was higher for IndependentChoices participants than for controls. The large increase in the proportion of eligible beneficiaries receiving paid assistance at nine months is laudable if it is attributable to family members and friends' providing care to consumers who, because of shortages of agency workers, would not have received paid help without the demonstration. However, some control-group members not receiving PCS at enrollment might have declined to seek agency services because they were only interested in the monthly allowance ("induced demand"). Although this would imply that the traditional program was unacceptable to some eligible beneficiaries, it also suggests that IndependentChoices might have increased state Medicaid spending by providing cash payments to people who (although entitled to services) would not otherwise have sought agency care.

We cannot fully sort out how much of the increase in the proportion receiving paid assistance was attributable to worker shortages and how much to induced demand. Had induced demand been widespread, we would have expected a large influx of new personal assistance users during the demonstration period. However, the ratio of new to continuing PCS users among IndependentChoices enrollees was never greater than the analogous ratio for the state's PCS recipients in the year preceding the demonstration start-up. In addition, some people who were not willing to accept agency services were deterred from enrolling by the requirement that demonstration enrollees agree beforehand that they would seek agency services if assigned to the control group. Furthermore, as we learned in follow-up interviews with agencies, worker shortages were common and at times severe during the demonstration period, sometimes forcing them to turn away clients, especially new ones. The fact that agencies supplied a much smaller-than-usual proportion of the hours authorized in the care plan suggests that they had insufficient staff to meet even the needs of their existing patients.

While worker shortages definitely account for some of the treatment-control difference in the receipt of paid care, the high rate of new control-group members receiving no paid care suggests that the difference is also partly attributable to induced demand. There are a number of possible reasons why some beneficiaries chose not to accept the agency services for which they were eligible, including past dissatisfaction with such services. Whatever the reason, IndependentChoices met a key goal: It increased the likelihood that beneficiaries receive paid help with the services they need and are authorized to receive.

Ultimately, what matters to states is the net effect of Cash and Counseling on all Medicaid costs. Increased spending for PCS because of induced demand were offset somewhat by lower spending for other long-term care services during the first postenrollment year and offset almost entirely during the second. Offsetting savings in these long-term care spending could grow even more over time.

ARKANSAS' EXPERIENCE HAS DEMONSTRATED that states can design a "cash and counseling" program that meets recipients' needs better at no greater cost per month of service than historically incurred under the traditional agency approach ("budget-neutrality" under the definition of the Centers for Medicare and Medicaid Services, or CMS). Even if total costs for PCS are higher than they would have been as a result of the improved access to care or induced demand, they appear to be offset by reduced need for other long-term care services. The better the traditional agency model is at meeting authorized needs, the greater the likelihood of immediate savings from a "cash and counseling" alternative. The worse the agency model performs, the greater the likelihood that spending will increase initially under the cash and counseling model, but the greater the need for this option to ensure adequate access to home care as an alternative to higher-cost Medicaid services, especially nursing home care.

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NOTES

1. U.S. General Accounting Office, *Long-Term Care: Federal Oversight of Growing Medicaid Home and Community-Based Waivers Should Be Strengthened,* Pub. no. GAO-03-576 (Washington: GAO, 20 June 2003).
2. L. Foster et al., "Improving the Quality of Medicaid Personal Assistance through Consumer Direction," 26 March 2003, www.healthaffairs.org/WebExclusives/Foster_Web_Excl_032603.htm (27 October 2003). This paper also provides further details about the Cash and Counseling program.
3. For methodological details and mean baseline characteristics of the sample, see S. Dale et al., "The Effect of Consumer Direction on Personal Assistance Received in Arkansas" (Princeton, N.J.: Mathematica Policy Research Inc., April 2003).
4. The pattern of expenditure impacts was similar for the elderly and the nonelderly, although the increase in PCS spending and the offsetting decrease in non-PCS spending were both greater for the nonelderly.
5. Foster et al., "Improving the Quality of Medicaid Personal Assistance."